



**TESTIMONY OF
Terri DiPietro MBA, OTR/L
SUBMITTED TO THE
APPROPRIATIONS COMMITTEE
Friday, March 6, 2015**

**HB 6824, An Act Concerning The State Budget For The Biennium
Ending June Thirtieth 2017, And Making Appropriations Therefor
And Other Provisions Related To Revenue**

Middlesex Hospital appreciates the opportunity to submit testimony concerning **HB 6824, An Act Concerning The State Budget For The Biennium Ending June Thirtieth 2017, And Making Appropriations Therefor And Other Provisions Related To Revenue**. My name is Terri DiPietro, and I have had the opportunity to serve on the Behavioral Health Partnership Oversight Council since January of 2009 and as Co-Chair of The Connecticut Hospital Association's Mental Health and Substance Abuse Subcommittee since 2012.

Given the already overwhelming issue of adequate access to outpatient behavioral health services, I come here today to voice my strong opposition to the proposed reduction in Medicaid coverage for some adults and the \$25 million in grant funding cuts for mental health treatment. I come here this evening to demonstrate my concern regarding the impact these cuts will bring and my willingness to be part of the solution. I urge you to reach out to the people who provide these services and consider creative ways to provide high quality continuing care within the community. When patients feel their only option for care is through the Emergency Department (ED), while they still receive high quality care, that care can only address the immediate acute needs and not the enduring disease. The cost of ED and inpatient services is far greater than it would be to invest in community treatments that allow patients to develop a recovery plan.

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I have had the privilege of being a founding member of the Middlesex County Community Care Team (CCT). We are a group over 14 provider agencies that meet for an hour each week at Middlesex Hospital to address clinical concerns for frequent visitors to the Emergency Department. Our process is simple; we identify the barriers that a patient is experiencing that lead to the patient's perceived need to present to the emergency room ED. Using a care coordination model, we develop a care plan to connect the patient to the appropriate services within the community and then monitor that plan until the patient is established in their recovery.

In a three-year period, we have reviewed 192 ED patients, some with 10 visits in a 6 month period and some with as many as 70 visits in a year. The lessons learned have been many. We have witnessed a dramatic reduction in visits once a CCT plan is in place. The crucial elements have been communication, collaboration, and the ability to follow a patient from the ED to the community and monitor his or her progress. At times that monitoring can be formal, by an ACT team or another clinical provider, or it may be the soup kitchen staff providing the bridge that allows the patient to get to a medical provider.

There are many stories of success that I can share, but I would like to highlight two. The first is a woman we'll call Jane. Jane was first referred to the CCT through the St. Vincent DePaul Soup Kitchen in 2013. She was experiencing chronic homelessness and had significant behavioral health issues and borderline intellectual functioning. During the calendar year 2012, Jane had 30 ED visits; in 2013 the team developed a care plan that included admission to the Intensive Outpatient Program at Middlesex Hospital with aftercare at the Adult Outpatient Clinic. In 2013, Jane's visits were reduced to 11. In 2014, she had two visits, both for medical conditions. She was diagnosed with the flu Flu A on one visit. This is an important story, as despite being very ill with the flu, Jane called her outpatient behavioral health providers, and explained that she would be missing her appointment, and why. Later that same year, there was a problem with her medical cab. She called the program to explain why she would be missing her appointment. She said and shared that she had already called and complained to the medical transportation and explained that she needed her therapy to stay out of the hospital. I mention these details because prior to being followed by the CCT, several of her visits to the ED were due to lack of follow-up with outpatient care providers. So for Jane, the combination of a coordinated care plan (and that she was one of the fortunate patients that with whom the CCT was working with that had qualified for and obtained supportive housing) -made all the difference.

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The second case is Liz. While Liz's story does not have as positive an outcome as Jane's, it is an important story to tell. Liz had experienced chronic homelessness, severe and persistent mental illness, and addiction to crack cocaine. She had many visits to the Middlesex Hospital Emergency Department ED, CCU^[A1], and medical units. Liz was fortunate that she was able to obtain supportive housing in 2014. However, a tragic but important lesson was learned by the CCT as we worked with Liz. Not all individuals manage the transition from chronic homelessness to supportive housing with the same results. For Liz, her enduring addiction issues led to arrests and ongoing admissions. She was incarcerated in the fall of 2014 and was released from jail within the last month. She is still housed. However, her years of substance use and life on the streets have left her with a deteriorating health course.

~~She~~ Currently, she requires a walker to ambulate, her Chronic Obstructive Pulmonary Disease has further limited her ability to ambulate, and she has a number of cardiac concerns. Through all of this, the CCT has monitored her progress and remains involved. So when she was recently hospitalized and required specific medical follow-up, the hospital was able to notify both the housing care manager and her treatment team at the local mental health agency, and her and clinical needs are being managed. Without the CCT release of information and the collaboration of multiple providers, it is unlikely she would likely not have followed up on these appointments.

Much of the infrastructure of our community care team was already in place when we started this project. The 14 involved providers were all doing their very best for their patients within their own silos. With a grant from DMHAS and a commitment from Middlesex Hospital's ED and Behavioral Health Leadership, the CCT has helped to reduce the frequent visitor population to our ED by more than over 50%. Our team has been keeping data, and we believe the dollars invested by DMHAS that fund our health promotion advocate within the ED have led to significant savings in ED and inpatient costs while engaging high volume ED users in community care environments.

Middlesex Hospital is one of the 14 CCT providers, and plays a critical role in providing all types of medical services to Connecticut residents, including mental and behavioral health services. The Center For Behavioral Health Outpatient Services served more than 3,000 outpatients in fiscal year FY 2014. This includes 22,650 adult outpatient visits and 6,639 child/adolescent visits. We provided just under 9,000 Partial Hospital/Intensive Outpatient visits for patients who struggle with behavioral health-related conditions. Connecticut Hospitals provide a full continuum of treatment for patients with behavioral

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health diagnoses with the fundamental goal of managing a patient's recovery within the community where they work and live.

As you know, it is not unheard of for a patient experiencing a mental health crisis to spend days, or even weeks, in our ED waiting for a bed in an appropriate facility, or waiting to be transitioned to the right outpatient setting, simply because there are not enough resources available to meet the constant need.— These extended stays in the ED can be stressful and often exacerbate a patient's condition rather than improve it. This problem is particularly acute for children and adolescents, for whom the need for services greatly outstrips the number of available beds and trained specialists.

These are some of the very real and negative results of ever-diminishing funding for vital behavioral health services, and the problem will grow if the Governor's proposed budget is enacted. The Governor's proposed budget would reduce Medicaid coverage for some adults and cut close to \$25 million in grants to fund mental health treatment. These reductions will tax the state's mental health system, intensifying the already extreme burden placed on our ED and outpatient clinics as we deliver mental health services.

The Connecticut Hospital Association has determined that an appropriation of \$3 million to the Department of Mental Health and Addiction Services will be sufficient to support grants to hospitals across the state for CCTs and related care coordination services, specifically for administrators to manage the CCTs and navigators/intensive case managers to coordinate the mental health and social service needs of each patient.

I am asking you to oppose cuts to the mental health system and, instead, invest in turning this innovative, community-based solution into a statewide best practice that will benefit patients, relieve pressure on providers, and achieve savings for the state.

Thank you for your consideration of our position.

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